Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gabriel Habib, MD

Respondent Name
Insurance Company of the State of PA

MFDR Tracking Number
M4-15-1082-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, but he did not perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s), that means he should bill using the appropriate MMI CPT code 99456 with the component modifier -26. Reimbursement for the examining doctor is 80% of the MAR.

The physical therapist and/or health care provider other than the examining doctor that performs the range of motion, strength, or sensory testing of the musculoskeletal body, the physical therapist and/or health care provider will bill with the component –TC. In this instance, reimbursement to the physical therapist and/or health care provider is 20% of the MAR.

The bills from the two parties must be coordinated and billed appropriately and should be billed at the same time for the correct reimbursement.

EXAMPLE

$350.00 for exam + $300.00 for range of motion

99456 – 26 @ $650.00 (80%) = $520.00
99456-TC @ $650.00 (20%) = $130.00

Total Reimbursement is $650.00

We have met the burden of proof that the Carrier has received the claim with a copy of the facsimile transmission report to the Carrier. Enclosed is a facsimile transmittal that shows the Carrier received the bill in a timely manner.

We see full reimbursement for the outstanding balance of $150.00 along with interest accrued according to Rule 134.803 Calculating Interest for Late Payments on Medical Bills.

We have met the burden of proof of our fair and reasonable rate with the aforementioned documentation."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Insurance Company of the State of PA has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). It is the Carrier's position that there is no additional money owed to the requestor, Dr. Gabriel Habib, MD for a 4/2/2014 DD Exam. The doctor is stating that he was not paid properly. The Carrier is going to maintain their denial that the additional $150 is not owed to the requestor, Dr. Habib. I have attached the three EOB's (4/28/14, 6/2/14 and 10/20/14) for your review.

According to Rule 134.202 of the Texas Workers' Compensation Act & Rules, a doctor is paid $350 for exam (MMI) and either $150 for the DRE Model or $300 if range of motion is used. Based on the fact that the doctor did

not provide any range of motion measurements to the right hand/fingers, the Carrier did not pay the additional $300. Instead, the Carrier paid a total of $500 ($1300 requested) on 5/13/2014. This is based on the fact that according to the DWC69, Dr. Habib used Figure 17, page 30 and Figure 7, page 24 which deal with finger amputation to determine the claimant's impairment rating."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2014	Designated Doctor Examination	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing designated doctor examination.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - P300 – The amount paid reflects a fee schedule reduction.
   - 150 – Payer deems the information submitted does not support this level of service.
   - VRNA – No Reduction Available.
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - VF01 – Documentation does not support level of service billed.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is the correct MAR for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used." The submitted documentation indicates that the Designated Doctor performed an evaluation to determine the impairment rating of the right index finger and right thumb using the DRE method found in the AMA Guides 4th edition. Therefore, the correct MAR for this examination is $150.00.
2. The total allowable for the disputed services is $500.00. The insurance carrier paid $500.00. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	March 2, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.